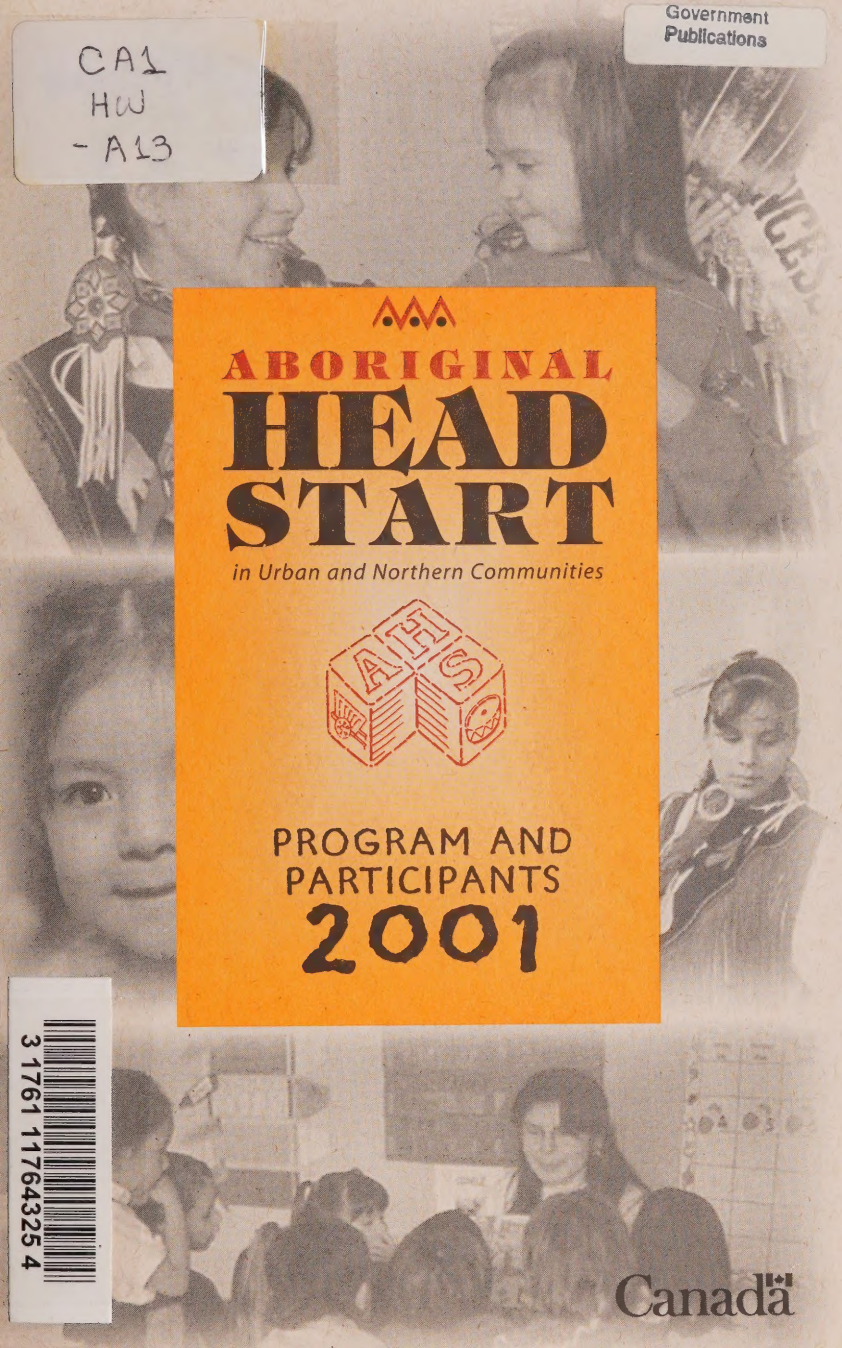

ABORIGINAL HEAD START

in Urban and Northern Communities

PROGRAM AND PARTICIPANTS 2001

Canada

Our mission is to help the people of Canada maintain and improve their health.
Health Canada

Également offert en français sous le titre: Le Programme et les participants (2001)

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INTRODUCTION

Aboriginal Head Start in Urban and Northern Communities

Aboriginal Head Start (AHS) is a Health Canada-funded early childhood development program for First Nations, Inuit and Métis children and their families living in urban and northern communities. The program focuses on the spiritual, intellectual, physical and emotional growth of each child and supports the parents to meet the child's developmental needs. It helps parents to build new skills and enhance family relationships and by linking them to appropriate service providers. The premise of Aboriginal Head Start is that successful adulthood is rooted in healthy early childhood development. The primary goal of AHS is to demonstrate that locally controlled and designed early intervention strategies can provide Aboriginal children with a positive sense of themselves, a desire for learning and opportunities to develop fully as successful young people.

All AHS sites include programming in: Aboriginal culture and language; education and school readiness; health promotion; nutrition; parental involvement; and social support. AHS coordinates and builds linkages with other local services and agencies, but often it is the only Aboriginal-specific children's program in the community. Projects involve parents and communities in the design and implementation of projects. Typical sites provide direct service to children between the ages of three and five and their families in a structured preschool setting. AHS sites reflect the variety of First Nations, Inuit, and Métis cultures and languages.

Program and Participants 2001

AHS is committed to the ongoing collection of data from AHS sites. Collecting data allows the program to compile statistics and evidence regarding the activities and administration of AHS sites, and to support reports and claims that the program is operating at full capacity, and could utilize more resources. This maintains community and government confidence in sites' ability to deliver AHS. Each year, the National Process and Administration Evaluation Survey collects demographic and descriptive data from each AHS site about participants and their communities, site operations, needs and finances. Data are highly useful in explaining and promoting the program within and outside government. AHS is located in all regions of the country, and data are analysed to capture the sites' diversity in size, geographic location, culture, language and style of program delivery. The different types of AHS communities are identified when analyzing the survey data because of factors that are relevant to program delivery (e.g. the cost of operating a site may be significantly higher or lower, or access to local training opportunities and health professionals may be very restricted). AHS sites are located in small urban communities, large urban communities, remote communities and isolated communities. Figure 1 illustrates the location and type of AHS sites, and will be useful to turn back to when you encounter data in this report that

FIGURE 1

Geographic Location and Types of 114 AHS Communities in Canada

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Erratum

Re: Figure 1 Geographic Location and Types of 114 AHS Communities in Canada

Exact geographic locations of AHS communities may not be as depicted in this image. In addition, the symbol designating 'isolated' locations actually indicates remote locations, and the symbol designating 'remote' locations indicates isolated locations.

FIGURE 1

Geographic Location and Types of 114 AHS Communities in Canada

distinguishes between the different types of AHS communities[1].

[1] The following definitions of types of AHS communities combined data from Statistics Canada (i.e. population size and community accessibility), and administrative data about AHS site operations.
Large Urban: communities with more than 75,000 residents, or those less than 20 kilometres away from a community with more than 75,000 residents.
Small Urban: communities with less than 75,000 residents that are less than 300 kilometres away from a community with more than 75,000 residents.
Remote: communities on a remote island over 300 kilometres away from a community with more than 75,000 residents; or that have access by road in winter only; or access by air only; or that must use a ferry part of the way, and that are more than 300 kilometres away from a community with more than 75,000 residents.
Isolated: communities with less than 75,000 residents that are more than 300 kilometres away from a community with more than 75,000 residents; or must travel by loose-surface highway part of the way to reach a community with more than 75,000 residents; or must travel by train part of the way to reach a community with more than 75,000 residents; or must use a ferry part of the way, and that are less than 300 kilometres away from a community with more than 75,000 residents.

This is the third report in a series of annual survey results for Aboriginal Head Start (AHS) in Urban and Northern Communities. It presents highlights of the survey findings in 2001. Approximately 98 percent of AHS sites across the country consistently participate in national evaluation activities. This confirms the high level of commitment and dedication of AHS staff across Canada, and to the high standards that AHS demands.

Several changes were made to the survey used in 2001. It is similar to the survey used in 2000 (the results of which were published in *Program and Participants 2000*). In 2001, changes were made to improve clarity, to reduce the amount of duplicative reporting, and to secure more detailed information in particular areas of interest (e.g. special needs). The number of questions was significantly reduced, deceasing the reporting burden on sites and leaving outcome-related data to be gathered through the National Impact Evaluation.

In 2001, the survey required AHS sites to provide responses that are collaborative by including the participation of: the AHS team member responsible for completing the survey; the site director or administrator; a parent; and a sponsor representative. Sites were provided with the self-administered mail-in survey to complete in three months.

The National Process and Administrative Evaluation Survey is different from the National Impact Evaluation. The impact evaluation will describe the changes in children, parents and communities as a result of participating in AHS. It will report data on the impact of all of the six program components. In 2001 and 2002, AHS is pilot testing impact evaluation tools in five AHS sites. Analysis of impact evaluation pilot testing, and subsequent impact evaluation results will be made publicly available.

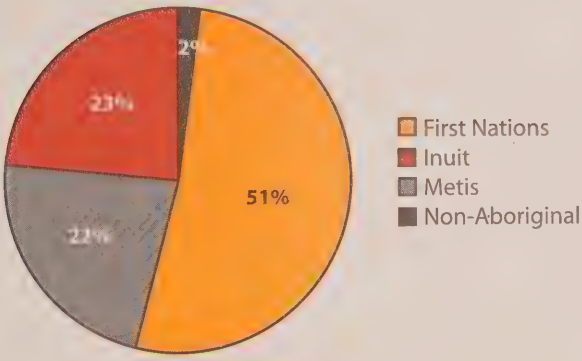
THE PARTICIPANTS

The Children

A total of 3,536 children enrolled in AHS in 2001, up from 3,126 in 2000. Most (85 percent of children) are between the ages of three and five. The age distribution of children participating has remained relatively stable over time with some sites also providing service to two- and six-year-olds. Eighty-four percent of children attend either morning or afternoon sessions and the others attend full-day sessions. Of the children enrolled, 1,870 are First Nations, 830 are Métis, 787 are Inuit, and 84 are non-Aboriginal.

FIGURE 2

Percentage of AHS Children That are First Nations, Inuit or Métis

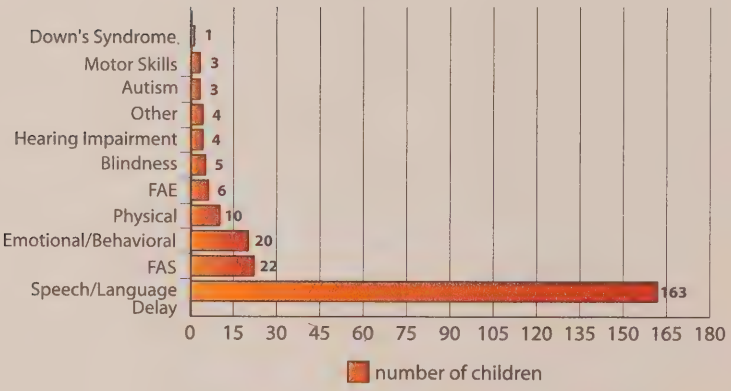


In 2001, specific questions were asked about special needs to obtain more detailed information on the overall capacity of AHS to provide services to children with special needs, and to identify ways to support sites in becoming more effective at supporting these children. Improving the capacity of all AHS sites to meet the needs of children with special needs is a priority for AHS.

Eighty-four percent of sites have at least one participating child with a special need. There were 241 children diagnosed with a special need enrolled in AHS. Speech and language delays were by far the most frequently diagnosed special need in AHS, followed by Fetal Alcohol Syndrome and emotional and behavioral disorders. This was consistent with findings in 1999 and 2000, with the exception of hearing impairments, which ranked second in 2000. These results stress the need for putting priority on staff training to assist children with speech and language delays and other special needs. Figure 3 presents the range and number of diagnosed special needs in AHS.

FIGURE 3

Diagnosed Special Needs of Children in AHS



An additional 319 children were identified as having special needs by AHS staff. The reluctance of parents to have their child diagnosed is the most common reason (in 52 percent of cases) that children are not diagnosed. Distance makes seeking a specialist to have an assessment unfeasible in 40 percent of cases. Long waiting lists to see specialists, a lack of project resources and a lack of AHS staff trained in the area of special needs also contributes to children not receiving a diagnosis. Only eight percent of sites have a trained special needs worker on site, but this is an improvement from zero sites in 2000.

Thirty-nine percent of sites have developed policy and procedures to address the needs of children with special needs as recommended in the National AHS Principles and Guidelines. Since the program began, 22 AHS sites have had to refuse enrollment of a child as a result of their special need. Thirty-seven sites have made structural adjustments to their site to accommodate children with special needs. Thirty-nine sites have obtained other funding to assist in supporting children with special needs. The province provided this funding in 67 percent of those sites, the local public school system in 13 percent and local community programs in five percent. One site accessed funding through a private grant and another through Brighter Futures[2].

The Parents

AHS recognizes parents and guardians as the child's primary teacher, and supports the role of the extended family in teaching and caring for children. AHS sites are managed in such a way that parents can have a meaningful experience in the planning, development, and evaluation of the program. Sites regularly provide and communicate about opportunities for parents to

[2] ***Brighter Futures*** is a Health Canada-funded, Canada-wide program designed to assist First Nations and Inuit communities in developing community-based approaches to children's programs. The purpose is to improve the quality of, and access to, culturally sensitive wellness services in the community.

participate in AHS. Parents are encouraged to contribute their unique skills and abilities and are supported to further develop as role models for their children. Forty-three sites have a full-time parent outreach worker.

Involving fathers in AHS programming is a specific focus for 17 AHS sites. Activities targeted at engaging father participation are: Dads Can[3] Groups; men's retreats; sharing lunch programs; workshops; meetings; father's circles; and family days. Three percent of sites have team members who specifically work with fathers.

[3] ***Dads Can*** is an evolving national charitable organization based in London, Ontario. Its roots are found in the 'Dad Class', a prenatal program for the new father. The mission of Dads Can is to re-enculturate a fatherhood ideal by promoting responsible and involved fathering through the support of men's personal development into fatherhood and healthy fathering patterns in our society.

THE AHS PROGRAM COMPONENTS

ABORIGINAL CULTURE AND LANGUAGE
PARENTAL INVOLVEMENT
NUTRITION
EDUCATION AND SCHOOL READINESS
HEALTH PROMOTION
SOCIAL SUPPORT

Specific activities in each of the program component areas do not change significantly from year to year, and detailed data in this area are not collected annually. In 2001, AHS sites were asked questions about only three of the program components. Information was gathered regarding Aboriginal languages, school readiness assessment/testing, and parental participation on parent advisory committees. This was done because specific information in these areas was needed to prepare for the impact evaluation. The National AHS Principles and Guidelines provide an excellent overview of the six program components, as do past evaluation reports (i.e. *Children Making a Community Whole: A Review of AHS,* and *Program and Participants 2000*).

Aboriginal Languages in AHS

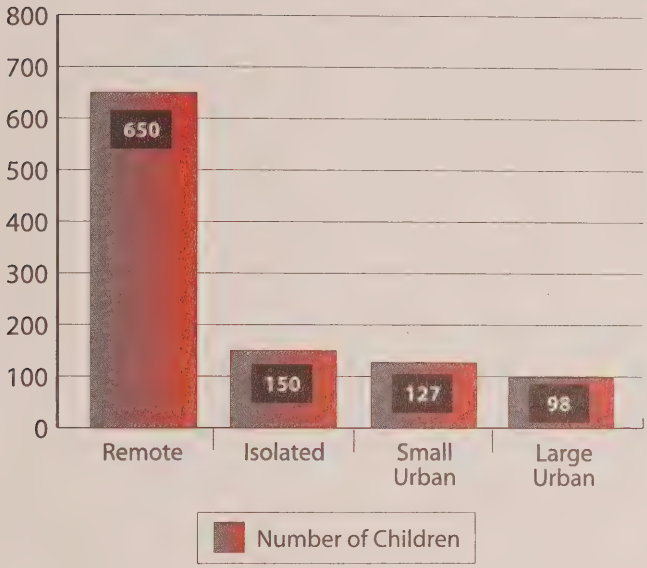
AHS sites provide opportunities for participants to enhance their knowledge of their respective Aboriginal languages and cultures. Seventy-five percent of sites reported that English is the primary language used in the site, while three percent primarily use French. Ninety-seven percent of AHS sites are teaching an Aboriginal language in the classroom daily, or everyday. The profile of Aboriginal languages taught in sites has remained relatively consistent since 1999. Cree is taught in 46 percent of sites, Inuktitut in 21 percent, Ojibwe in 17 percent, and Saulteaux in seven percent. The diversity of Aboriginal languages spoken in AHS reflects the overall diversity of the program. Other languages taught in AHS are:

Algonquin;
Atikamek;
Blackfoot;
Carrier;
Chipewyan;
Dakota;
Dene;
Dogrib;
Gwich'in;
Hal'qu'em'elem;
Inuinnagtun;
Inuvialuktun;
Kaska;
Michif;
Mik'maq;
Mohawk;
Innu;
Northern Tutchone;
Oneida;
Slavey;
and Smalgyax.

Nine hundred and eighty (28 percent) children in AHS are able to speak an Aboriginal language fluently. Sixty-six percent of the children who speak an Aboriginal language live in remote communities. Thirteen percent of these children attend projects in small urban communities, 11 percent in isolated communities and ten percent in large urban communities. Figure 4 presents the place of residence and number of AHS-participating children who speak an Aboriginal language, by type of community.

FIGURE 4

Place of Residence of Children who Speak an Aboriginal Language by Community Type



Child Assessment/Testing in AHS

Part of the National Impact Evaluation will focus on measuring children's school readiness. In order to know which sites were already engaged in child assessment to gauge school readiness, sites were asked if they have been involved in testing children for program evaluation purposes. Forty-two percent of sites reported

they were, and 19 percent reported they were planning to begin testing in 2002. The Brigance[4] is the most frequently used test (in nine sites), followed by a High/Scope method (in six sites). Provincial testing/screening tools are used in five sites, non-standardized tests in five sites, and the DISC[5] in four sites.

Parental Participation on Parent Advisory Committees

Parents participate on parent councils or other governing bodies that oversee the operations of AHS sites in 85 percent of sites. Typically, these governing bodies that meet approximately ten times per year are comprised of seven parents and three other family members. Participating on Parent Advisory Committees is one way for parents to develop new skills and to have an impact on how their site operates.

[4] **Brigance** refers to an approach to assessment that consists of criteria-referenced instruments designed for use in programs for infants and children below the developmental level of seven years. This inventory identifies a child's specific strengths and weaknesses in pre-ambulatory motor skills, gross motor skills, fine motor skills, self-help skills, pre-speech, speech and language, reading readiness, and basic math.

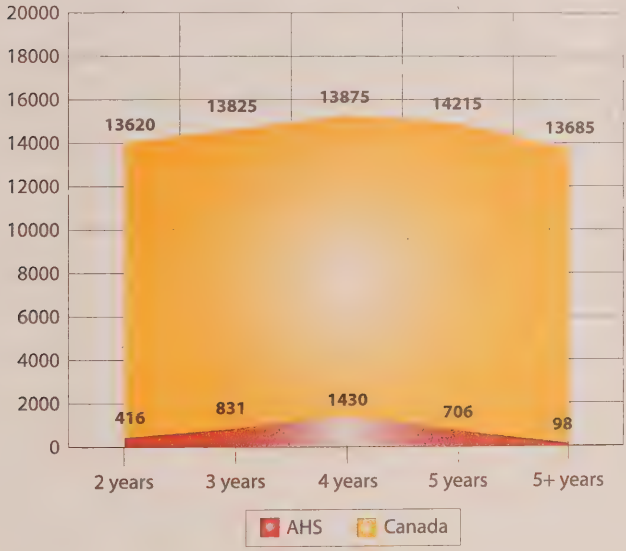
[5] The **Diagnostic Inventory for Screening Children (DISC)** assesses developmental skills in eight areas: fine motor; gross motor; receptive language; expressive language; auditory attention and memory; visual attention and memory; and self-help and social skills. This diagnostic screen bridges the gap between a first-stage developmental screen and a thorough diagnostic assessment. It identifies specific skill areas in which the child is showing deficits.

THE REACH OF THE PROGRAM

There were 41,915 three- to-five-year-old Aboriginal children living in urban and northern communities across Canada according to 1996 Census data (the primary target group for AHS). There were 2,967 children in this age group enrolled in AHS in urban and northern communities in 2001. AHS is reaching approximately seven percent of its primary target group.

FIGURE 5

Aboriginal Children Served by AHS Compared With the Number of Aboriginal Children Living Off Reserve in Canada by Age (1996 Census)



In 2001, there were 114 AHS sites in eight provinces and three northern territories. Seventy-four percent of sites reported that they could not enroll all of the children in their community in need of AHS. Thirty-six percent of sites were unsure how many more children they could enroll in their current facility given the appropriate resources, while others indicated that they could enroll an additional 1,171 children.

Forty-six percent of AHS sites operate ten months of the year, and 16 percent operate year round. The majority (73 percent of sites) provide AHS programming four days per week. The others offer programming two, three, or five days per week. Special summer camp programs are offered by 16 percent of AHS sites and operate from one to ten weeks.

The Speech From the Throne on January 30, 2001 reiterated the Government of Canada's commitment to securing a better future for Aboriginal children. The Speech stated that the government will expand significantly the Aboriginal Head Start program, to better prepare more Aboriginal children for school and help those with special needs.

The federal government's 2001 Budget confirmed that additional funding would be made available to a number of Aboriginal early childhood development programs, including Aboriginal Head Start.

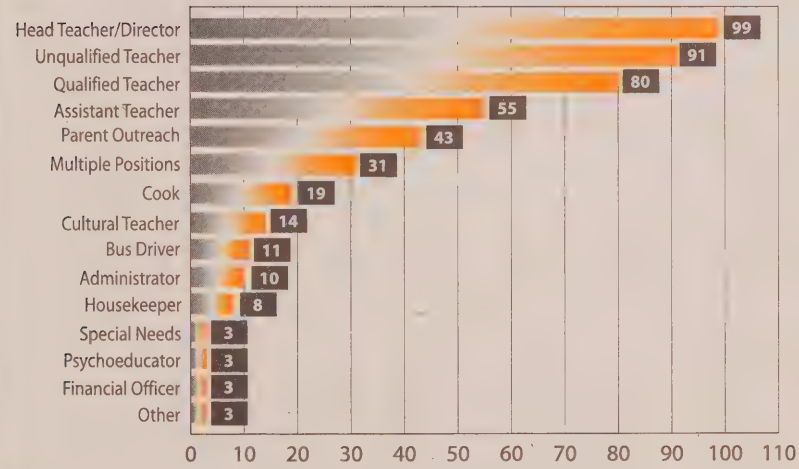
PROGRAM STAFF, ADMINISTRATION AND FINANCES

Program Staff

There are 707 staff working in AHS sites across Canada; 530 are in full time positions. Eighty-nine percent of them are Aboriginal (90 percent of full time staff, and 87 percent of part time staff are Aboriginal). Non-Aboriginal staff are most often employed as special needs aides, speech pathologists, and psycho-educators. Figure 6 illustrates the types and numbers of full time positions in AHS sites.

FIGURE 6

Number of Full Time Staff by Position



Forty-seven percent of AHS staff working directly with children are certified[6] (i.e. formally trained). The number of certified classroom staff members varies significantly depending on the geographic location of the AHS site. In large urban communities, for example, 81 percent of AHS staff are certified; while in remote communities, 21 percent of staff are certified. Forty-six percent of staff in small urban communities are certified, and 30 percent in isolated communities. Sites were asked if they had a nearby accredited early childhood education (ECE) course available to them, which has a probable impact on the number of certified staff available to hire locally. All sites in large urban communities have access to ECE training. Sixty-eight percent of sites in small urban communities do, and 56 percent of isolated communities have access. In remote communities, 43 percent have access to ECE training. It is interesting to note that all of the sites in remote communities that have access to training are located in Nunavik (northern Quebec). This means that none of the AHS sites in other remote communities of the country have easy access to accredited ECE training.

Significant differences exist in staff wages depending on the site's location. AHS staff that work in small urban sites earn the least, followed by staff in large urban sites, and then staff in isolated sites. Staff in remote communities earn the most.

Administration and Finances

Salary costs account for the majority of sites' budgets. The median cost of operating an AHS site is $212,168. There is a wide variability of allocations to sites depending on the size, location, and particular partnership arrangements[7]. Seventy-three percent of sites offer bus or van service to participants. Providing transportation to and from the site has the potential to increase the reach of the program.

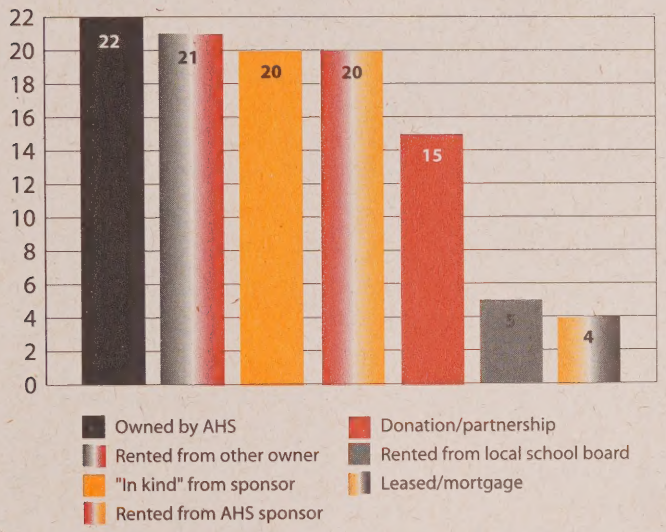
[6] A certified teacher has any of the following: Early Childhood Education, Early Childhood Development, Level II or III Early Childhood Development, Masters of Education or other related graduate degree, and Bachelors of Education or other related degree.

[7] For example, in 1999, an agreement was made between Health Canada and the Kativik Regional Government in Nunavik, northern Quebec, which allowed all of Nunavik's child care centres to provide the Aboriginal Head Start Program to the children. Health Canada funding (initially intended for two AHS sites) in this region is divided among these centres. As a result, Health Canada funding to AHS sites in Nunavik is lower on a per-site basis because most funding comes from other sources.

Forty-three percent of AHS sites rent space, and 21 percent own their facility. Figure 7 shows the various arrangements that AHS sites have with regard to their facility. Operational costs for AHS sites potentially decrease if the site is able to purchase its own facility. But, in some cases, the benefits of renting space in a shared facility (i.e. with other family-oriented services) may outweigh the benefits of owning a building.

FIGURE 7

Number of Projects That Own, Rent or are Housed in Donated Space



PROGRAM NEEDS

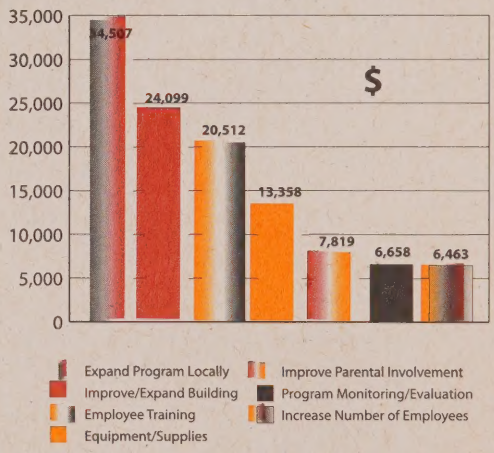
In 2001, AHS sites were asked to list their five most important needs in rank order. In preparation for an enhancement and expansion of the program, AHS sites called for increased funding to:

- *Provide training for their employees;*
- *Improve or expand AHS facilities;*
- *Increase the number of employees;*
- *Expand the program locally;*
- *Offer, increase, or improve transportation;*
- *Increase employee benefits;*
- *Develop/distribute culture and language resources;*
- *Purchase additional equipment or supplies.*

The top four needs identified were the same in 1999 and 2000. Sites were asked to identify how much money would be required to address these needs in sites. Program expansion, building expansion and employee training are identified as the most important needs, and the most costly. Figure 8 presents what AHS sites estimate that each of these program needs would cost.

FIGURE 8

Estimated Cost of Addressing Program Needs per Project by Type of Need



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All AHS sites include programming in: Aboriginal culture and language; education and school readiness; health promotion; nutrition; parental involvement; and social support. AHS coordinates and builds linkages with other local services and agencies, but often, it is the only Aboriginal-specific children's program in the community. Projects directly involve parents and communities in the design and implementation of projects. Typical sites provide direct service to children between the ages of three and five and their families in a structured preschool setting. The diversity of First Nations, Inuit, and Métis cultures and languages is reflected in the 114 AHS sites operating in Canada.

Program and Participants 2001 is the third report in a series of annual process evaluation survey results for Aboriginal Head Start (AHS) in Urban and Northern Communities. It presents highlights from the National Administrative and Process Evaluation Survey 2001, and contains data regarding characteristics of the program and its participants, project administration and coordination, program components, and program needs and finances. Ninety-eight percent of AHS sites across the country consistently participate in this national evaluation activity. This attests to the high level of commitment and dedication among AHS sites across Canada, and to the program's high standards.